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September 21, 2007

TO: Legislative Oversight Committee
Local CFAC Chairs
NC Council of Community Programs
NC Assoc. of County Commissioners
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Professional and Stakeholders Organizations
NC Association of County DSS Directors
Commission for MH/DD/SAS
State CFAC
County Board Chairs
County Managers
LME Director
DHHS Division Directors
Provider Organizations

FROM: Mike Moseley

William W. Lawrence, Jr., M.D.

RE: **Implementation Update #35:** CAP-MR/DD Waiver Transition

The federal Centers for Medicare and Medicaid Services (CMS) has approved an amendment to North Carolina's CAP-MR/DD waiver with an effective date of July 1, 2007. This amendment includes implementation of a new policy related to service provision by legally responsible individuals, relatives, and legal guardians, ***Services and Supports Provided by Legally Responsible Individuals, Relatives, and Legal Guardians.*** This policy is attached to this memo. The entire technical amendment to the CAP-MR/DD waiver is posted on the Division of Mental Health, Developmental Disabilities, Substance Abuse (DMH/DD/SAS) website at http://www.ncdhhs.gov/mhddsas/cap-mrdd/capwaiverdocs.htm.

In order to ensure a smooth transition to the policy ***Services and Supports Provided by Legally Responsible Individuals, Relatives, and Legal Guardians*** outlined in the Technical Amendment to the CAP-MR/DD waiver, the following transition process will be followed:

- Local Management Entities (LME) are responsible for providing written communication to CAP-MR/DD consumers and legally responsible persons via US Mail of this change in policy. A copy of the actual policy must be attached to the communication.

- Case managers will have no longer than six months from the date of approval of the Technical Amendment or until February 22, 2008, to assist consumers and family members in transition to the limitations outlined in the policy. Case managers will be responsible for providing information regarding qualified providers and staff within their catchment area and documenting that information clearly in the consumer record. Case management providers should contact the provider relations section of the LME if they need information regarding qualified providers in their area.

    - **There will be no exceptions to completion of the transition within the six months.**
    - In order to ensure that case managers complete the process within the six month timeframe, case management agencies will be responsible for submitting a list of consumers and family members impacted by the transition to the Local Management Entity (LME).
    - Based on the list submitted, the case management provider agency will be responsible for providing a monthly update to the LME indicating progress toward transitioning those impacted to the new policy. This will enable the LME to monitor the progress of the transition on a monthly basis to ensure timeliness of completion and to provide technical assistance as needed. **This may include care coordination activities by the LME with specific provider agencies serving specific consumers impacted by the new policy.**

- Since the transition to the policy will not result in reduction or increase in the amount or frequency of service there will be no requirement for completing a Plan of Care Update/Revision for formal submission to Value Options. However, if there is a change in provider agency, Value Options must be notified through the usual process of that change. Case managers must complete the cover sheet of the newly revised Plan of Care in order to clearly indicate that services are provided by the legally responsible person, relative, or guardian. This new cover sheet will be added to the consumer record. A copy of the revised cover sheet of the Plan of Care is attached to this memo.

- Case managers and providers are responsible for insuring that the limitations outlined in the policy are adhered to as a component of ongoing monitoring of service delivery outlined in the CAP-MR/DD Manual in Section 5 and 6.

- Verification that the transition to the policy has occurred will be reviewed during the Continued Need Reviews by the statewide utilization review vendor.

As noted in the attached policy, payment may be made to individuals who serve as legal guardians **of the person** only. Those individuals, regardless of whether or not they have a familial relationship to the waiver recipient, may provide up to 217 hours of medically necessary services to their ward in a calendar month, provided they meet all provider qualifications. If the guardian of the person is a relative, the other requirements of family members as service providers above also apply.

In circumstances in which the guardian of the person chooses/requests to provide the paid care to their ward the following process will be followed:

1. Upon completion and signing of the Plan of Care (POC) by the planning team, the Plan of Care is submitted to the Local Management Entity (LME) Care Coordination Unit for review of the appropriateness of the request for the guardian to provide paid care.
2. A checklist outlining specific criteria will be developed by the Department of Health and Human Services (DHHS) and used by the Care Coordinator to assist in the review process. Items on the checklist will include information regarding quality of care concerns related to the provision of care by the guardian.
3. If the Care Coordinator is in agreement with the frequency of hours of service to be provided by the guardian, as well as frequency and duration of services included in the POC, a formal written recommendation for approval is made. This approval recommendation will be attached to the POC by the case manager as a component of the packet sent to the statewide utilization review vendor for medical necessity review.
4. If the Care Coordinator determines that it appears that provision of services by guardian of the person is not appropriate, or the hours requested appear to exceed medical necessity, the Care Coordinator will write a recommendation of disapproval. This recommendation will be attached to the POC by the case manager as a component of the packet sent to the statewide utilization vendor for medical necessity review.
5. The statewide utilization vendor will consider the Care Coordinator's recommendation in reviewing the POC. If the utilization vendor denies or reduces the hours requested, the guardian will be provided with the appropriate appeal notice and rights.

Attachments:
Services and Supports Provided by Legally Responsible Individuals, Relatives ,and Legal Guardians
Revised cover sheet of the Plan of Care
Criteria for Review of Legal Guardians of the Person Providing Paid Supports under the CAP-MR/DD Waiver

cc: Secretary Dempsey Benton
Dan Stewart
DMH/DD/SAS ELT
Tom Galligan
DMA Assistant Directors
Sharnese Ransome
Kaye Holder
Wayne Williams
Mark VanSciver
Brad Deen
Walker Wilson